AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Lexington Park
930 Highway 466
Lady Lake, Florida 32159

Re: Directed Plan of Correction

Dear Administrator:

A representative of this Agency completed a complaints survey, CCR #2013007677 and CCR #2013008002 on . 2013. Non- compliance was found at the time of the visit.

The Agency for Health Care Administration (AHCA) is imposing a Directed Plan of Correction (DPOC). Should Lexington Park fail to comply with the DPOC and achieve substantial compliance, the AHCA may take administrative action which may include revocation of the assisted living license.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

You are directed to perform the following:

1. Within 7 days of the receipt of this notice, audit 100% of resident records to review and compare physician medication orders to the Medication Observation Record, (MOR) for accuracy.

2. Within 10 days of the receipt of this notice, the administrator, nursing care managers and staff who provide medication directly to the residents or are involved in the processes related to medications shall receive in-service education related to pain management for the Hospice patients, and how to medications dosing using proportional The training must be provided by a Hospice Pharmacist, or if not available, the facility must arrange the training to be provided by a licensed pharmacist with experience and knowledge in pain management. The training must be a minimum of 4 hours which includes a competency examination. Staff must obtain a passing score of at least 100%. Documentation of this testing must be maintained for review by the Agency.

3. The facility must develop and implement policy and procedures within seven (7) days of this notice that define the process of the transcription of medications orders for one month's Medications Observation Record (MOR) to the next month's MOR and a process for the comparison of the medications label to the actual physician order. The policy and procedure(s) must include that only a licensed nurse will perform the

verification process. The policy and procedure(s) must include documentation of an ongoing monitoring program.

4. The facility must develop and implement policy and procedures within seven (7) days of this notice that define the process for the identification of medication doses ordered, but not provided to the residents, and the actions to be taken when medications are not available. The policy and procedure(s) must include actions to be taken by the staff to obtain the medication, the notification of the nursing care manager, and how occurrences of the medications not being available will be monitored.

Sincerely,

Stephe Burgin for

Kriste J. Mennella
Field Office Manager

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967925	08/06/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lexington Park	930 Highway 466 Lady Lake, FL 32159	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= G

Specific Tag Findings:

0000-Initial Comments

On unannounced complaint survey CCR #2013007677 & 2013008002 was conducted at Lexington Park Assisted Living Facility in Lady Lake Florida. Discernible deficiencies were identified as a result of this survey. The facility was not in compliance at this time.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record reviews and interviews the facility did not provide adequate care or supervision for 1 of 7 residents, for resident #1.

Findings:

On a record review was conducted on the facility's investigation concerning an injury which was sustained by resident #1 on . According to statements taken by the facility, a hospice aid reported she gave resident #1 a shower by herself and after the shower the aid noticed resident #1 leg was red and . Because resident #1 did not show any signs or symptoms of pain nothing further was done.

On a record review of resident #1 health assessment 1823 dated states resident #1 needs the physical assist of 2 persons for transferring.

Upon further record review of the facility's investigation. It was noted that an Licensed Piratical Nurse (LPN) stated that on at 10:15 PM she was notified by a resident aid that resident #1 was observed to have and redding of the lower lateral leg at the top of her right foot X2 to the bottom of her right foot. The statement further revealed that the resident is unaware of how she got the . The incident report was placed in the Advanced Registered Nurse Practitioner (ARNP) book. The ARNP was not notified of the resident #1 condition until at 10:10 AM. Once the ARNP was notified X-rays were ordered and it was discovered resident #1 had a tibal base of her right leg.

On at approximately 9:25 AM an interview was conducted with the facility's Nursing Care Manager in reference to the facility's policy on reporting an injury of a resident. She stated that because the resident did not complain about any pain the LPN did not report it immediately to the physician. The Nursing Care Manager further stated that if she had been in that situation she would have called the doctor.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, interviews and record reviews it was determined the Assisted Living Facility failed to

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administer medication in accordance with the health care providers order for 2 of 7 residents for residents #1 & #2.

Findings:

On at approximately 12:43 PM an interview was conducted with the Nursing Care Manager (NCM) in reference to resident #1 receiving the wrong dosage of . She stated the order for the was 5 milligrams (mgs) every 4 hours. The medication label from the pharmacy stated 5 milliliters every 4 hours. The pharmacy also sent a 1 ml syringe with prescription. The Medication Observation Record (MOR) was written " give 5 ml ' s every 4 hours as needed for pain " The NCM stated that an unlicensed person reconciled the month of MOR with the month of MOR and the error was not caught. NCM said both Licensed Practical Nurses (LPNs) involved in the incident regarding resident #1 were placed on suspension pending the results of the Medical Examiners office.

A review of resident #1's MOR for both the month of and 2013. The MOR for the month showed resident #1 was prescribed Roxanol 20 mg per 1 ml and 5 mg Q4hrs PRN (every 4 hours and as needed). However no Roxanol was administered for the month of

The MOR revealed that resident #1 had been prescribed 100 MR :00, Give 5ML's every 4 hours as needed for pain/Sh . According to the MOR and written statements from LPN E she administered 5ML ' s of at 10:30 AM and then again at 8:30 PM on .

A written statement from LPN F was obtained and revealed, on at 8:00 AM LPN F administered 1ml of and decided to check the physicians order because she thought the dosage on the prescription and MOR were unusually high, and discovered the transcription error.

On a record review was conducted of both resident #1 medication label and the prescription written by the physician. The Physician order was written for Roxonal 20 mg/ml 5 mg Q4 PRN. The medication label came into the facility 100 mg/5 ML ROXANOL 20 MG/ML solution, which is noted on the MOR for the month of 2013.

On at approximately 2:00 PM a medication review was conducted in the memory unit. Six residents were observed having medication administered to them by LPN B. During a record review of the MOR it was observed that resident #2 had not received her for five days which she takes for Esphogeal Refulx . LPN B said it was order with the pharmacy and it was in but had not yet been delivered.

On at approximately 4:00 PM an interview was conducted with Nursing Care Manager in reference to resident #2 being 5 days without her which she said this was unacceptable. She later returned and said that the family did not want to pay for the medication and new orders needed to be written.

Class II